| Division of Medical Assistance | Clinical Coverage Policy No.: |
|---|---|
| Dietary Evaluation and Counseling | Original Effective Date: June 1, 2001 |
| | Revised Date: |

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# 1.0 Description of the Service

Dietary Evaluation and Counseling (Medical Nutrition Therapy) offers direction and guidance for specific nutrient needs related to a patient's diagnosis and protocol. Individualized care plans provide for disease-related nutritional therapy and counseling.

# 2.0 Eligible Recipients

## 2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

## 2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. While there is no requirement that the service, product, or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount, or frequency described in this coverage policy do not apply if the product, service, or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at http://www.dhhs.state.nc.us/dma/prov.htm.

## 2.3 Children through 20 Years of Age

Children through 20 years of age are eligible for dietary evaluation and counseling when they meet the medical necessity criteria listed in **Section 3.2**.

## 2.4 Pregnant and Postpartum Women

Pregnant and postpartum women are eligible for dietary evaluation and counseling when they meet the medical necessity criteria listed in **Section 3.2**.

# 3.0 When the Service Is Covered

## 3.1 General Criteria

Medicaid covers dietary evaluation and counseling when it is medically necessary and:

1. the service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs.
2. the service can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide.
3. the service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

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### 3.2 Medical Necessity Criteria

#### 3.2.1 Children through 20 Years of Age

Medicaid covers dietary evaluation and counseling for children through 20 years of age when there is a chronic, episodic, or acute condition for which nutrition therapy is a critical component of medical management, including but not limited to:

1. inappropriate growth/weight gain such as inadequate weight gain, inappropriate weight loss, underweight, obesity, inadequate linear growth, or short stature
2. nutritional anemia
3. eating or feeding disorders that result in a medical condition such as failure to thrive, anorexia nervosa, or bulimia nervosa
4. physical conditions that impact growth and feeding such as very low birth weight, necrotizing enterocolitis, cleft palate, cerebral palsy, and neural tube defects
5. chronic or prolonged infections that have a nutritional treatment component such as HIV or hepatitis
6. genetic conditions that affect growth and feeding such as cystic fibrosis, Prader-Willi Syndrome, or Down Syndrome
7. chronic medical conditions such as cancer, chronic or congenital cardiac disease, hypertension, hyperlipidemia, gastrointestinal diseases, liver disease, pulmonary disease, malabsorption syndromes, renal disease, significant food allergies and diseases of the immune system
8. metabolic disorders such as inborn errors of metabolism (PKU, galactosemia, etc.) and endocrine disorders (diabetes, etc.)
9. Non-healing wounds due to chronic conditions
10. Acute burns over significant body surface area
11. Metabolic Syndrome/Type 2 diabetes
12. a documented history of a relative of the first degree with cardiovascular disease and/or possessing factors that significantly increase the risk of cardiovascular disease such as a sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, higher than ideal body weight.

#### 3.2.2 Pregnant and Postpartum Women

Medicaid covers dietary evaluation and counseling for pregnant women when the pregnancy is threatened by chronic, episodic, or acute conditions for which nutrition therapy is a critical component of medical management, and for postpartum women who need follow-up for these conditions or who develop such conditions early in the postpartum period, including but not limited to:

1. conditions that impact the length of gestation or the birth weight, where nutrition is an underlying cause, such as:
   a. severe anemia (HGB<10M/DL or HCT<30)
   b. pre-conceptionally underweight (<90% standard weight for height)
   c. inadequate weight gain during pregnancy
   d. intrauterine growth retardation
   e. very young maternal age (under the age of 16)
   f. multiple gestation
   g. substance abuse
2. metabolic disorders such as diabetes, thyroid dysfunction, maternal PKU, or other inborn errors of metabolism

3. chronic medical conditions such as cancer, heart disease, hypertension, hyperlipidemia, inflammatory bowel disease, malabsorption syndromes, or renal disease,
4. auto-immune diseases of nutritional significance such as systemic lupus erythematosus
5. eating disorders such as severe pica, anorexia nervosa, or bulimia nervosa
6. Obesity when the following criteria are met:
   BMI >30 in same woman pre-pregnancy and post partum
   BMI >35 at 6 weeks of pregnancy
   BMI >30 at 12 weeks of pregnancy
7. a documented history of a relative of the first degree with cardiovascular disease and/or possessing factors that significantly increase the risk of cardiovascular disease such as a sedentary lifestyle, elevated cholesterol, smoking, high blood pressure, higher than ideal body weight.

# 4.0 When the Service Is Not Covered

## 4.1 General Criteria

Dietary evaluation and counseling is not covered when:

1. the recipient does not meet the eligibility requirements listed in **Section 2.0.**
2. the recipient does not meet the medical necessity criteria listed in **Section 3.0**.
3. the service duplicates another provider's procedure.
4. the service is experimental, investigational, or part of a clinical trial.

# 5.0 Requirements for and Limitations on Coverage

## 5.1 Service Components

Dietary evaluation and counseling must include all of the following service components:

1. a review of medical management, an evaluation of medical and psychosocial history, and treatment plan as they impact nutrition interventions.
2. an assessment of living conditions related to nutrition evaluation such as possession of a working stove, refrigerator, and access to city water or tested well water
3. a diagnostic nutritional assessment, which may include:
   - review and interpretation of pertinent laboratory and anthropometric data
   - analysis of dietary and nutrient intake
   - determination of nutrient–drug interactions
   - assessment of feeding skills and methods
4. development of an individualized nutrition care plan
   - recommendations for nutrient and calorie modification
   - calculation of a therapeutic diet for disease states such as diabetes, renal disease, and galactosemia
   - referral to other health care providers
5. counseling on nutritional/dietary management of nutrition-related medical conditions.
6. consultation with the recipient's primary care provider.
7. education on reading food labels

### 5.2 Service Setting

Dietary evaluation and counseling must be provided as an individual, face-to-face encounter with the recipient or the recipient's caretaker.

### 5.3 Service Limitations

The initial assessment and intervention is limited to four units of service per date of service and cannot exceed four units per 270 days by the same or different provider.

The re-assessment and intervention is limited to four units of service per date of service and cannot exceed 20 units per 365 days by the same or different provider.

## 6.0 Providers Eligible to Bill for the Service

Medicaid enrolled providers who employ or contract with licensed dieticians/nutritionists or registered dieticians (for example, local health departments, rural health centers, federally qualified health centers, physician or medical diagnostic clinics, outpatient hospitals and physicians) are eligible to bill for this service.

### 6.1 Provider Qualifications

Dietary evaluation and counseling provided in public agencies, private agencies, clinics, physician or medical diagnostic clinics, and physician offices must be performed by:

1. a dietitian/nutritionist, currently licensed by the N.C. Board of Dietetics/Nutrition (provisional license is not acceptable); OR
2. a registered dietitian, currently registered with the Commission of Dietetic Registration (registration eligibility is not acceptable).

### 6.2 Staff Qualifications

It is the responsibility of the provider agency to verify in writing all staff qualifications for their staff's provision of service. A copy of this verification (current licensure or registration) must be maintained by the provider agency.

## 7.0 Additional Requirements

### 7.1 Medical Record Documentation

Medical record documentation must be maintained for each recipient, for at least five years, and include, at a minimum:

1. the date of service
2. the presenting problem
3. a summary of the required nutrition service components
4. the signature of the qualified nutritionist providing the service
5. the recipient's primary care or specialty care provider's order for the service
6. documentation shall be maintained in the medical records of the recipient's primary care provider

### 7.2 WIC Program

All individuals categorically eligible for the WIC Program must be referred to that program for routine nutrition education and food supplements.

**Note:** For agencies that also administer a WIC Program, the nutrition education contacts required by that program must be provided prior to billing Medicaid for dietary evaluation and counseling. Staff time utilized to provide a Medicaid-reimbursable nutrition service may not be charged to WIC program funds.
Dietitians/nutritionists providing dietary evaluation and counseling are encouraged to refer eligible clients to the Maternity Care Coordination or Child Service Coordination programs as appropriate.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date: June 1, 2001**

**Revision Information:**

| Date | Section Revised | Change |
| --- | --- | --- |
| | Section 6.0 | Providers eligible to bill for the services were expanded to include outpatient hospital clinics, physician and medical diagnostic clinics, and physician's office. |
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# Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in the Medicaid Managed Care programs.

**A. Claim Type**

1. Health departments, children's developmental service agencies, federally qualified health centers, rural health clinics, physician or medical diagnostic clinic and physicians enrolled in the N.C. Medicaid program bill services on the CMS-1500 claim form.

   **Note:** FQHCs and RHCs must bill using their provider number and the alpha suffix "C."

2. Hospital outpatient clinics enrolled in the N.C. Medicaid program bill services on the UB-92 claim form.

**B. Diagnosis Codes**

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

One of the primary diagnosis codes listed below must be used when the recipient is 21 years of age or older.

| | | | | |
|---|---|---|---|---|
| V22.0 | V22.1 | V22.2 | V23.0 | V23.1 |
| V23.2 | V23.3 | V23.4 | V23.5 | V23.7 |
| V23.81 | V23.82 | V23.83 | V23.84 | V23.89 |
| V23.9 | V24.2 | 278.00 | 278.01 | 783.7 |
| 783.41 | | | | |

**C. Procedure Code(s)**

| | |
|---|---|
| 97802 | Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes |
| 97803 | Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes |

**D. Revenue Codes**

Hospital outpatient clinics bill for services using RC 942 **and** CPT code 97802 or 97803.

**E. Modifiers**

Providers are required to follow applicable modifier guidelines.

**F. Billing Units**

1. CPT code 97802
   - Each 15 minutes of service equals 1 billing unit.
   - Service is limited to a maximum of 4 units per date of service.
   - Service cannot exceed 4 units per 270 days.

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2. CPT code 97803
   - Each 15 minutes of service equals 1 billing unit.
   - Service is limited to a maximum of 4 units per date of service.
   - Service cannot exceed a maximum of 20 units per 365 days.

3. Revenue Code 942 and CPT codes 97802
   - Each 15 minutes of service equals 1 billing unit.
   - Service is limited to a maximum of 4 units per date of service.
   - Service cannot exceed 4 units per 270 days.

4. Revenue Code 942 and CPT codes 97803
   - Each 15 minutes of service equals 1 billing unit.
   - Service is limited to a maximum of 4 units per date of service.
   - Service cannot exceed a maximum of 20 per 365 days.

**G. Place of Service**

Dietary evaluation and counseling shall be provided in hospital outpatient clinics, public agencies such as health departments, federally qualified health centers, and rural health clinics, private agencies, physician or medical diagnostic clinics and physician offices.

**H. Copayments**

Pregnancy related services and services for children ages 0 through 20 years of age are not subject to copayment requirements.

**I. Reimbursement**

Providers must bill their usual and customary charges. All agencies must bill the same fee for all recipients who receive the same service.